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	155412	A. BUILDING 00 B. WING	07/15/2011

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F0000	This visit was for Recertification and State Licensure survey. Survey dates: July 11th, 12th, 13th, 14th, and 15th, 2011 Facility number: 000509 Provider number: 155412 AIM number: 100266620 Survey team: Leia Alley, RN, TC Marcy Smith, RN Barbara Hughes, RN Karina Gates, BHS Census bed type: SNF/NF: 98 Total: 98 Census payor type: Medicaid: 69 Medicare: 16 Other: 13 Total: 98 Sample: 20 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 7/20/11	F0000	**This plan of correction is to serve as Greenwood Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Greenwood Health and Living Community or their management companies that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Cathy Emswiller RN			
F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. 1. Based on record review and interview the facility failed to ensure plans of care for diabetes were followed for blood sugars being called to the physician and insulin being administered as ordered for 4 of 4 residents reviewed for diabetic care in a sample of 20. (Residents #94, #41, #48 and #20) 2. Based on interview and record review the facility failed to ensure a resident did not continue to receive a medication after it was discontinued by the physician for 1 of 17 residents reviewed for following physician's orders in a sample of 20. (Resident #25) 3. Based on observation, interview, and record review the facility failed to ensure a resident on a no added salt diet did not receive added salt for 1 of 12 residents reviewed for receiving the appropriate diet order recommended by the physician. (Resident #52) 4. Based on record review and interview, the facility failed to ensure a resident,	F0282	**F282 483.20(k) (3) (ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** **I. Resident #25's Metoclopramide was discontinued on 7/12/11. Resident #52's diet was clarified with the physician during the survey process and the NAS order was discontinued. Resident #52 is receiving a diet as ordered by the physician. Any blood sugar out of ordered parameters for residents #94, #41, #48 and #20 are being called to the physician. Resident #107 no longer resides at this facility.** **II. Any resident with a pharmacy medication recommendation for the last 30 days will be audited for completion. All resident diets will be audited to cross reference diet slips and physician orders for accuracy. All residents with blood sugar and insulin orders will be reviewed for notification of physician and administration of insulin. All NPO (nothing by mouth) residents have been**	08/14/2011

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	with a physicians order to have nothing by mouth, did not receive fluids by mouth for 1 of 1 resident in the sample of 20 with physicians orders for NPO (nothing by mouth). Findings included: 1.a) The record of Resident #94 was reviewed on 7/12/11 at 8:50 a.m. Diagnoses for Resident #94 included, but were not limited to, diabetes mellitus and end stage renal disease. A physician's order a dated 5/3/11, indicated the resident was to receive accuchecks (a fingerstick blood test to measure blood sugar) twice a day on Monday, Wednesday and Friday and the physician was to be notified if the resident's blood sugar reading was less than 60 or over 250. A care plan for Resident #94 dated 5/11/11 indicated a problem of "Risk for hypo/hyperglycemia [low/high blood sugar] r/t [related to] diagnosis of Diabetes." Approaches/interventions included, but were not limited to "...7. Monitor lab reports and notify MD...9. Perform and document accu-checks per MD's orders..."		**audited for accuracy of documentation/administration of fluids and none were found.** **III. The systemic change includes:** **a. All pharmacy recommendations will be given to and monitored by the Director of Nursing or designee. The Director of Nursing or designee will distribute recommendations to the unit managers and a copy will be returned to the Director of Nursing or designee, to monitor for completion.** **b. All physician orders will be reviewed in daily clinical stand up meeting for communication with dietary department.** **c. All blood sugar results have been placed in a new format on the medication administration record and diabetic testing log has been placed in the medication administration record for documentation of blood sugars outside parameters and physician notification. Previous blood glucose testing log has been removed.** **d. All sliding scale insulin orders have been placed in a new format on the medication administration record to include time, blood sugar result and the amount of insulin given.** **e. The charge nurses will**	

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	Review of the resident's Diabetic Testing Log for May, 2011, indicated the following: 5/4/11 at 4:00 p.m. blood sugar = 282 5/21/11 at 6:00 a.m. blood sugar = 252 5/23/11 at 4:00 p.m. blood sugar = 289 Review of the resident's Diabetic Testing Log for June, 2011, indicated the following: 6/8/11 at 4:00 p.m. blood sugar = 292 6/14/11 at 4:00 p.m. blood sugar = 267 There was no documentation in the resident's record to indicate the physician had been called about these elevated blood sugars which were outside the call parameters. 1.b) The record of Resident #20 was reviewed on 7/14/11 at 2:00 p.m. Diagnoses for Resident #20 included, but were not limited to, diabetes mellitus and hypoglycemia. A recapitulated physician's order for July, 2011, with an original date of 1/3/10, indicated the resident was to get a "finger stick blood sugar 4 times daily." A recapitulated physician's order for July, 2011, with an original date of 8/13/10, indicated the resident was supposed to		**include monitoring of Matrix fluid documentation for residents with NPO orders in their end of shift duties.** **Education will be provided to licensed nursing staff on the new pharmacy recommendation procedure, dietary orders and communication, diabetes management and documentation, and Matrix documentation as it relates to residents who are NPO.** **IV. The Director of Nursing or designee will review/audit:** **a. The pharmacy recommendations for completion once weekly on an ongoing basis.** **b. Diet orders changes and new admission diet orders in clinical stand up meeting with Certified Dietary Manager or designee for accuracy with diet cards five times weekly an ongoing basis.** **c. Medication administration records to include diabetic testing log will be audited for blood sugar results, physician notification, and amount of insulin given five times weekly for 1 month, then three times weekly for 1 month, then once weekly for 1 month, then once monthly for duration of 12 months.** **d. Matrix fluid documentation**	

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	receive Novolog Insulin, based on the results of the finger stick, according to the following sliding scale: Blood sugar = 125-149: 2 units Blood sugar = 150-174: 3 units Blood sugar = 175-199: 4 units Blood sugar = 200-224: 5 units Blood sugar = 225-249: 6 units Blood sugar = 250-274: 8 units Blood sugar = 275-299: 9 units Blood sugar = 300-324: 11 units Blood sugar = 325-349: 13 units Blood sugar = 350-374: 14 units Blood sugar = 375-399: 15 units Blood sugar over 400: call MD Review of Diabetic Testing Log for June, 2011, indicated the following finger stick results: 6/5/11 at 6:00 a.m. blood sugar = 135 - 2 units should have been given and were not. 6/7/11 at 6:00 a.m. blood sugar = 163 - 3 units should have been given and were not. 6/12/11 at 6:00 a.m. blood sugar = 136 - 2 units should have been given and were not. 6/19/11 at 6:00 a.m. blood sugar = 209 - 5 units should have been given and were not. Review of the June, 2011 Medication Record did not indicate any insulin was		**for NPO residents five times weekly for 1 month, then three times weekly for 1 month, then once weekly for 1 month, then once monthly for duration of 12 months.** **The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **V. Completion date: August 14, 2011.**	

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	given to the resident for the above fingersticks according to the sliding scale. During an interview with the DoN on 7/15/11 at 10:00 a.m. she indicated she did not know if any insulin was given to Resident #20 for the above blood sugars. 1.c) The clinical record for Resident #48 was reviewed on 7/15/11 at 9:45 a.m. Diagnoses for Resident #48 included, but were not limited to: Diabetes Mellitus, Hypertension, Anemia, Dementia with Psychosis, and Depression. A recapitulation of July, 2011 physician's orders indicated Resident #48 was to have an Accucheck (a blood test to determine the glucose level in the blood) twice daily at 6 a.m. and 4 p.m. The orders indicated the physician was to be contacted if the results were less than 60 or above 350. The orders indicated the resident received Novolog Insulin 16 Units subcutaneously 3 times daily (7:30 a.m., 12:00 p.m., and 5:30 p.m.). The orders indicated Novolog Insulin to be given per sliding scale based on the results of the Accucheck test as follows: 150-200=2 Units, 201-250=4 Units, 251-300=6 Units, and 301-350=8 Units.			

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	The diabetic testing log for Resident #48 indicated the resident's blood sugars were checked and in the range requiring insulin coverage per sliding scale on the following dates and times: 7/2/11 at 4:00 p.m. = 180 2 Units should have been administered and were not. 7/3/11 at 4:00 p.m. = 150 2 Units should have been administered and were not. 7/7/11 at 4:00 p.m. = 239 4 Units should have been administered and were not. 7/13/11 at 6:00 a.m. = 206 4 Units should have been administered and were not. The diabetic testing log and MAR (medication administration record) lacked any information relating to insulin coverage per sliding scale having been given as ordered by the physician based on the results noted above. The diabetic testing log indicated a blood sugar result of 179 on 7/10/11 at 6:00 a.m. The MAR indicated 4 Units of insulin were given and should have been 2 Units. The diabetic testing log indicated a blood sugar result of 266 on 7/10/11 at 4:00 p.m. The MAR indicated 4 Units of insulin were given and should have been 6 Units.			

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	The diabetic testing log indicated a blood sugar result of 215 on 7/15/11 at 6:00 a.m. The MAR indicated 3 Units of insulin were given and should have been 4 Units. 1.d) The clinical record for resident #41 was reviewed on 7/14/11 at 2:30 P.M. A Health Care Plan problem dated 3/3/11, indicated resident #41 had a potential for hyperglycemic or hypoglycemic episodes secondary to diabetes. A goal for this problem was for the resident to have no signs and symptoms of hypo/hyperglycemia daily. One intervention for this problem was medication and labs as ordered. Physician's orders, dated 6/28/10 indicated Resident #41 was to receive a subcutaneous injection of 40 units of Lantus at bedtime, a Novolog injection of 12 units to be given subcutaneously 3 times a day at 7:30 A.M., 12:00 P.M., and 5:30 P.M., and the resident was to have accuchecks (a blood test to determine the glucose level in the blood) before meals and at bedtime. The order indicated that the physician was to be contacted if the accucheck results were below 60 or above 350. The orders indicated that a Novolog sliding scale insulin injection for insulin coverage was to be given based on accucheck results between 201 and 400.			

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	The diabetic monitoring flowsheet for Resident #41 indicated the resident's accuchecks resulted in a range requiring insulin coverage on the following dates and times: (The sliding scale ordered was 0-200 = 0 units, 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, 401-450= 10 units.) 5/20/11 at 7:30 A.M. = 348 should have been 6 units given - none was listed 5/22/11 at 12:00 P.M. = 239 should have been 2 units given - none was listed 5/28/11 at 12:00 P.M.= 342 should have been 6 units given - none was listed 5/29/11 at 12:00 P.M. = 325 should have been 6 units given - none was listed 5/29/11 at 5:30 P.M. = 379 should have been 8 units given - none was listed 6/4/11 at 12:00 P.M. = 288 should have been 4 units given - none was listed 6/23/11 at 5:30 P.M. = 341 should have been 6 units given - none was listed The diabetic monitoring flowsheet, medication administration record, and the nursing notes for the dates and times			

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	noted above, lacked any information related to insulin coverage having been given as ordered by the physician based on the accucheck results noted above. During an interview with the DON on 7/14/11 at 2:45 P.M., additional information was requested regarding the lack of accucheck information as noted above for Resident #41. On 7/15/11 the DON indicated that after review of the records she could not find any additional information relating to insulin coverage for the above dates. On 5/12/11 at 4:00 P.M., the result of the accucheck for Resident #41 was 265 indicating that the Novolog sliding scale order of the accucheck between 251 and 300 required 4 units of insulin to be given. The MAR on this date indicated that 2 units had been given. On 6/5/11 at 4:00 P.M., the result of the accucheck for Resident #41 was 331 indicating that the Novolog sliding scale order of the accucheck between 301 and 350 required 6 units of insulin to be given. The MAR on this date indicated that 2 units had been given. An undated facility policy, titled "Diabetes Mellitus - Routine Care,"			

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	received from the Director of Nursing on 7/13/11 at 10:00 a.m. indicated "Purpose: To provide nursing staff with guidelines for implementing care for the resident with diabetes mellitus. Objective: To provide care that will enable the resident to achieve and or maintain control of diabetes...An abnormal lab or blood glucose must be called to the physician..." 2. The clinical record for Resident #25 was reviewed on 7/12/11 at 10:00 a.m. Diagnoses for Resident #25 included, but were not limited to: Cerebral Palsy, Dementia, Seizures, Anxiety, Depression, and Dysphasia. A Note to Attending Physician/Prescriber from the pharmacist dated 6/26/11 indicated a recommendation to discontinue Metoclopramide (a medication used to promote gastric emptying). The physician response portion dated 7/6/11 indicated the recommendation was accepted and for nursing/pharmacy to please execute request noted above. Review of the July, 2011 MAR (Medication Administration Record) for Resident #25 on 7/12/11 at 10:30 a.m. indicated Metoclopramide was administered three times on the following			

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	dates: 7/7/11 through 7/11/11 and one time on 7/12/11. Interview with the Director of Nursing on 7/12/11 at 4:40 p.m. indicated there must have been a miscommunication. She indicated she thought someone took the recommendation from the fax and filed it in the chart without writing an order for the pharmacy to discontinue and without transcribing it to the MAR. The policy for Medication Regimen Review Form Completion provided by the DON on 7/12/11 at 11:15 a.m. was reviewed on 7/12/11 at 11:25 a.m. The policy indicated if the pharmacist recommendation is accepted by the physician, the nurse will note the order and fax copy or phone order to the pharmacy, keep the original accepted recommendation in chart as an order if not rewritten, sign and date form, and note fax or phone order. 3. The clinical record for Resident #52 was reviewed on 7/12/11 at 9:45 A.M. Physician's orders dated 4/12/11 indicated that Resident #52 was to receive a regular diet, NCS (no concentrated sweets), and NAS (no added salt). On 7/13/11 at 8:35 A.M. Resident #52 was observed with open salt packets next			

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	to his plate. When he was interviewed at this time he indicated that he always put salt in his buttermilk. His menu was observed listing that he was NCS. NAS was not listed as ordered by physician. Interview was conducted with RN Unit Manager, North, on 7/13/11 at 2:00 P.M. when information was requested regarding any diet change for Resident #52. She indicated that the diet listed for 7/11 was his current diet and there had been no changes. On 7/14/11 at 12:50 P.M. Resident #52 was observed receiving his tray in his room with salt packets. The menu on the tray indicated his menu was NCS. NAS was not listed as ordered by physician. 4. The record for Resident #107 was reviewed on 7/11/11 at 2:00 p.m. Diagnoses included but were not limited to, tracheotomy stoma (an opening in the neck and throat that aides in breathing), respiratory failure, laryngeal resection (surgery to the larynx), and Gastric-tube placement. Resident #107 was admitted to the facility on 6/29/11 with a physicians order to be NPO (nothing by mouth). On 7/8/11 the facility's Speech Language Pathologist			

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	(SLP) wrote an order indicating Resident #107 "may have sips of water after intensive oral care." A "Vitals Report" that included fluid intake, and the amount of fluid ingested, indicated Resident #107 received fluid by mouth on the following dates; 6/30/11, 480 cubic centimeters (cc's) (2 cups), 7/1/11, 120 cc's (1/2 cup), 7/2/11 120 cc's (1/2 cup), 7/3/11 120 cc's (1/2 cup), 7/4/11 120 cc's (1/2 cup) 7/5/11, 360's (1 and 1/2 cups). Resident #107 was not to have anything by mouth until the order was written by the SLP on 7/8/11. An interview was held with the SLP on 7/14/11 at 3:00 p.m. She indicated she feels that Resident #107 can safely swallow small sips of water. An interview was held with DONS (Director of Nursing Services) on 7/14/11 at 4:30 p.m. She indicated she would review any documentation in regards to finding. On 7/15/11 at 10:00 a.m. DONS indicated no other information was available in regards to fluid intake. 3.1-35(g)(2)			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0325 SS=E	Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. 1. Based on record review and interview the facility failed to ensure significant weight losses were assessed for 4 of 7 residents reviewed for weight loss in a sample of 20. (Resident #3, #33, #13 and #25) 2. Based on observation, interview and record review the facility failed to ensure a resident received a therapeutic diet as ordered for 1 of 12 residents reviewed for receiving diets as ordered in a sample of 20. (#52) Findings include: 1. The record of Resident #3 was reviewed on 7/13/11 at 10:20 a.m. a. Diagnoses for Resident #3 included, but were not limited to, profound mental	F0325	**F325 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE** **I. Residents #3, #33, #13 and #25 have been reviewed for significant weight changes. Physician and family notification has been completed and residents #3, #33, #13, and #25 have been added to weekly at risk meeting and are being weighed weekly. Resident #52's diet was clarified with the physician during the survey process and the NAS order was discontinued. Resident #52 is receiving a diet as ordered by the physician.** **II. All resident weights have been reviewed via the weight variance report for the last 6 months. Those found to have had significant weight changes have been added to**	08/14/2011

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	155412	A. BUILDING 00 B. WING	07/15/2011

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	retardation, Edward's syndrome, epilepsy and dementia with severe agitation. A therapeutic diet care plan for the resident, originating 7/15/08 and updated through August, 2011, indicated a problem of "Resident requires a mechanically altered diet: Pureed." The goal was "Resident will consume at least 50% of meals offered." Approaches included "Monitor/record weight [each] month. Notify MD and family of significant weight change...Offer sub[stitute] when <50% of meal is consumed..." A physician's order with an original date of 9/30/10 indicated Resident #3 was to receive "Resource Cup (Magic Cup)" (a nutritional dietary supplement) at every meal. Review of a Weight Variance Report in the facility's computer on 7/14/11 at 11:55 a.m. indicated the following weights for Resident #3: 5/11/11 - 79.0 pounds 6/10/11 - 69.0 pounds This is a significant weight loss of 12.6% in 30 days 7/6/11 - 72.0 pounds There was no documentation the resident's record to support this significant weight		**the weekly at risk meeting, weekly weights have been initiated as needed, and referrals have been made to the dietician as necessary. All resident diets will be audited to cross reference diet slips and physician orders for accuracy.** **III. The systemic change includes:** **a. A weekly weight variance report will be reviewed by unit manager or designee for significant weight changes and if identified will be re-weighed for accuracy. Any resident with a significant weight change will be reviewed in the weekly at risk meeting for appropriate notification and interventions.** **b. All physician orders will be reviewed in daily clinical stand up meeting for communication with dietary department.** **Education will be provided to licensed nursing staff on Matrix documentation regarding accuracy of weight documentation and communication of dietary orders with dietary department.** **IV. The Director of Nursing or designee will review/audit:** **a. Weight variance report once weekly at the at risk meeting on an ongoing basis.** **b. Diet orders changes and**	

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	loss was assessed and addressed. The most recent dietary note reviewing the resident was dated 1/19/11. The next weight for the resident was done on 7/6/11. b. The record of Resident #33 was reviewed on 7/14/11 at 2:00 p.m. Diagnoses for Resident #33 included, but were not limited to, depression, anxiety, dementia with verbal abuse and aggression. A recapitulated order for July, 2011, with an original date of 10/6/09 indicated the resident was on a mechanical soft diet. A care plan for Resident #33, originating 7/15/08 and updated through 8/2011, indicated a problem of "Requires Therapeutic Diet: Mech[anical] Soft . The goal was "Resident will consume at least 50% of meals offered." Approaches included "...3. Offer sub[stitute] when less than 50% is consumed...5. Monitor...weight...notify physician of weight loss/gain of 5% in 30 days...6. Offer [bedtime] snack. 7. Supplement as needed..." Review of a Weight Variance Report for the resident, received from the DoN on		**new admission diet orders in clinical stand up meeting with Certified Dietary Manager or designee for accuracy with diet cards five times weekly on an ongoing basis.** **The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **I. Completion date: August 14, 2011.**	

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	7/15/11 at 11:00 a.m. indicated the following weights: 4/25/11: 244.0 pounds 5/14/11: 230 pounds 6/10/11: 238.6 pounds 7/6/11: 214.6 pounds The weight loss between 6/10/11 and 7/6/11 was a significant weight loss of 10.1% in 1 month. 1d) The record for Resident #13 was reviewed on 7/13/11 at 9:30 a.m. Diagnoses included but are not limited to, gastroesophageal reflux disease (gerd, stomach contents that come back up into the throat), history of dehydration, dysphasia (trouble swallowing), rheumatoid lung, and hypertension. Resident #13 was reviewed for weight loss. A weight loss summary was reviewed for the months January through June of 2011. From January through April Resident #13's weights were stable. On May 11th, 2011 the resident's weight was 159.4. The resident was weighed on June 10th, 2011 and had a documented weight of 133.7, indicating a 25.7 pound loss, 19 % of her body weight in 1 month. Further information was requested from DONS in regards to weight loss and documentation on 7/13/11 at 4 p.m. She			

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	indicated no further information was available. C. The clinical record for Resident #25 was reviewed on 7/12/11 at 10:00 a.m. Diagnoses for Resident #25 included, but were not limited to: Cerebral Palsy, Dementia, Seizures, Anxiety, Depression, and Dysphagia. Review of the Weight Variance Report provided by the DON (Director of Nursing) on 7/12/11 at 3:00 p.m. indicated the resident's weight was 169.2 pounds on 5/14/11 and 158.2 pounds on 6/10/11, a 6.5% weight loss of 11 pounds in 27 days. There was no documentation to support this significant weight loss was assessed and addressed. The physician's recapitulation orders for July, 2011 indicated Resident #25 was to have super cereal with breakfast. 2. The clinical record for Resident #52 was reviewed on 7/12/11 at 9:45 A.M. Physician's orders dated 4/12/11 indicated that Resident #52 was to receive a regular diet, NCS (no concentrated sweets), and NAS (no added salt). On 7/13/11 at 8:35 A.M. Resident #52			

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	was observed with open salt packets next to his plate. When he was interviewed at this time he indicated that he always put salt in his buttermilk. His menu was observed listing that he was NCS. NAS was not listed as ordered by physician. Interview was conducted with RN Unit Manager, North, on 7/13/11 at 2:00 P.M. when information was requested regarding any diet change for Resident #52. She indicated that the diet listed for 7/11 was his current diet and there had been no changes. On 7/14/11 at 12:50 P.M. Resident #52 was observed receiving his tray in his room with salt packets. The menu on the tray indicated his menu was NCS. NAS was not listed as ordered by physician. During an interview with the Director of Nursing Services (DoNS) on 7/14/11 at 11:10 a.m. she indicated the Unit Managers and she review the Weight Variance Reports. If a significant loss or gain is noted, the resident would be referred to the Interdisciplinary Team, supplements and weekly weights would be initiated. She indicated if a significant loss or gain is noted, the resident should be reweighed and this weight should be entered on the Weight Variance Report. She indicated Resident #13's weight loss			

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	in June, 2011 was missed. 3.1-46(a)(1)			
F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	1. Based on record review and interview the facility failed to ensure non-pharmacological measures were offered or attempted prior to giving an antianxiety medication for 1 of 17	F0329	**F329 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** **I. Resident #3 is no longer receiving as needed**	08/14/2011

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	residents reviewed for not being offered alternatives to antianxiety medication therapy in a sample of 20. (Resident #3) 2. Based on record review and interview the facility failed to ensure a resident no longer received a medication after it was discontinued by the physician for 1 of 17 residents reviewed for medications being discontinued in a sample of 20. (Resident #25) Findings include: 1. The record of Resident #3 was reviewed on 7/13/11 at 10:20 a.m. Diagnoses for Resident #3 included, but were not limited to, profound mental retardation, Edward's syndrome, dementia with severe agitation, anxiety and self mutilation. A care plan for the resident, with an original date of 12/15/10 and updated 6/29/11, indicated a problem of "Resident has repetitive physical movements...fidgeting in w/c [wheelchair], picking at skin, sucking/biting fingers, banging hands on tray." Approaches to the problem include reassuring and comforting the resident during acute periods, establishing a trusting relationship, assisting the resident		**antianxiety medication therapy. Resident #25's Metoclopramide was discontinued on 7/12/11.** **II. All residents with as needed antianxiety agents have been identified and are being reviewed for the use of non-pharmacological measures prior to the use of the medication. Any resident with a pharmacy medication recommendation for the last 30 days will be audited for completion.** **III. The systemic change includes:** **a. A new prn medication administration form has been added to the medication administration record for providing a non-pharmacological intervention prior to the use of antianxiety agents.** **b. All pharmacy recommendations will be given to and monitored by the Director of Nursing or designee. The Director of Nursing or designee will distribute recommendations to the unit managers and a copy will be returned to the Director of Nursing or designee, to monitor for completion.** **Education will be provided to licensed nursing staff regarding the new format non-pharmacological**	

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	to identify effective coping mechanisms, maintaining a calm environment and approach to the resident and following familiar routines. Another care plan, with an original date of 9/17/10 and updated 6/29/11, had a problem of "Resident has socially inappropriate/disruptive behavioral symptoms as evidenced by making loud noises, banging hands on tray, crying out and moaning." Interventions included, but were not limited to maintaining a calm environment, avoiding over-stimulation and providing comfort measures for basic needs ("i.e., pain, hunger, toileting, too hot/cold, etc.") A recapitulated physician's order for June, 2011, with an original date of 1/28/11, indicated the resident could have Diazepam (an antianxiety medication) every 4 hours as needed "for increased agitation and/or biting at hands." The Medication Record for Resident #3 for June, 2011, indicated he received Diazepam for biting his hands on 6/24 at 6:45 p.m., 6/25 at 10:30 a.m. and 5:00 p.m., 6/27 at 3:00 p.m. and 6/28 at 11:00 a.m. There was no documentation in the resident's record to indicate any non-pharmacological interventions had been offered or attempted prior to giving		**intervention prior to the use of antianxiety agents and the new pharmacy recommendation procedure.** **IV. The Director of Nursing or designee will review/audit:** **a. All residents with as needed antianxiety medication five times weekly for 1 month, then three times weekly for 1 month, then once weekly for 1 month, then once monthly for duration of 12 months for non-pharmacological intervention prior to use.** **b. The pharmacy recommendations for completion once weekly on an ongoing basis.** **The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **V. Completion date: August 14, 2011.**	

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	the Diazepam. An undated facility policy, received from the Regional Consultant on 7/14/11 at 11:55 a.m. titled "Psychotropic Drug Use" indicated "Policy...Non-pharmacological interventions will be utilized first to manage behaviors when appropriate..." During an interview with the Director of Nursing on 7/14/11 at 10:00 a.m. she indicated she was unable to provide further information on whether non pharmacological interventions had been attempted for Resident #3 prior to giving him the anti-anxiety medication. She indicated "We've already started working on a process for this." 2. The clinical record for Resident #25 was reviewed on 7/12/11 at 10:00 a.m. Diagnoses for Resident #25 included, but were not limited to: Cerebral Palsy, Dementia, Seizures, Anxiety, Depression, and Dysphagia. A Note to Attending Physician/Prescriber from the pharmacist dated 6/26/11 indicated a recommendation to discontinue Metoclopramide (a medication used to promote gastric emptying). The physician response portion dated 7/6/11 indicated the			

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	recommendation was accepted and for nursing/pharmacy to please execute request noted above. Review of the July, 2011 MAR (Medication Administration Record) for Resident #25 on 7/12/11 at 10:30 a.m. indicated Metoclopramide was administered three times on the following dates: 7/7/11 through 7/11/11 and one time on 7/12/11. Interview with the Director of Nursing on 7/12/11 at 4:40 p.m. indicated there must have been a miscommunication. She indicated she thought someone took the recommendation from the fax and filed it in the chart without writing an order for the pharmacy to discontinue and without transcribing it to the MAR. The policy for Medication Regimen Review Form Completion provided by the DON on 7/12/11 at 11:15 a.m. was reviewed on 7/12/11 at 11:25 a.m. The policy indicated if the pharmacist recommendation is accepted by the physician, the nurse will note the order and fax copy or phone order to the pharmacy, keep the original accepted recommendation in chart as an order if not rewritten, sign and date form, and note fax or phone order.			

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	3.1-48(a)(2)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions 1. Based on observation and interview, the facility failed to ensure fish and pureed eggs were held on the steam table at a temperature of 135 degrees Fahrenheit (F) or greater until the last resident was served. This had the potential of affecting 84 residents receiving a regular diet served from the kitchen and 9 residents receiving a pureed diet from the South Dining Room. 2. Based on observation and record review, the facility failed to feed residents under sanitary conditions for 1 of 6 residents receiving pureed food in the North dining room. 1. During an observation of food temperature checks in the kitchen with the Director of Dining Services after the last resident was served lunch on 7/11/11 at	F0371	**F371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY** **I. Fish and pureed eggs are held on the steam table at a temperature of 135 degrees Fahrenheit or greater until the last resident is served. C.N.A. #1 was educated/counseled during survey to proper resident feeding standards.** **II. Food temperature will be monitored with each meal service by dietary staff and audited by Certified Dietary Manager for accuracy. Audits will be conducted at random meal times by the unit manager or designee for proper feeding technique of residents.** **III. The systemic change includes:**	08/14/2011

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	12:15 p.m., the remaining fish on the steam table showed a temperature of 120 degrees F. During interview at that time the Director of Dining Services indicated at this time that "It should be warmer than that." During an observation of food temperature checks in the South Dining Room with the Director of Dining Services after the last resident was served breakfast on 7/13/11 at 8:55 a.m., the remaining pureed eggs on the steam table showed a temperature of 130 degrees F. During interview at that time the Director of Dining services indicated at this time they had just had their steam table repaired and she didn't "know why they're not staying warmer."		**a. A log sheet will be utilized to monitor holding temperatures with each meal service.** **b. Breaded meat items will be placed in a perforated pan and broth placed under to facilitate proper food temperatures.** **c. Nursing staff will be educated regarding proper feeding technique of residents.** **Education will provided to dietary staff regarding temperature monitoring.** **Education will be provided to nursing staff on proper feeding technique of residents.** **IV. The Director of Dining Services or designee will review/audit:** **a. Food temperature logs completed by dietary staff for accuracy and completion. In addition the Certified Dietary Manager will complete random food temperature audits with meal service three times weekly for 1 month, then once weekly for 4 months, and then once monthly for a duration of 12 months.** **The Director of Nursing or designee will review/audit:** **a. Meal service for proper feeding technique three times weekly for 1 month, then once**	

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	2. On 7/13/11 at 8:35 a.m. Resident #25 was observed eating breakfast in the North dining room. CNA #1 was feeding Resident #25 what appeared to be hot cereal. Prior to feeding a spoonful to Resident #25, CNA #1 put her face near the spoon and blew on it. Before feeding Resident #25 the next spoonful, CNA #1 put her face near the spoon and blew on it as well. Review of the Nutrition and Hydration in-service curriculum provided by the Director of Nursing on 7/15/11 at 9:30 a.m. and reviewed on 7/15/11 at 3:20 p.m. indicated when serving food, the CNA should stir hot foods to cool them. 3.1-21(i)(3)		**weekly for 1 month, then once monthly for duration of 12 months.** **The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **V. Completion date: August 14, 2011**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0425 SS=E	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation and record review, the facility failed to ensure insulin was disposed of after expiration dates. This affected 4 of 16 residents who received insulin Resident #'s, 22, 29, 59, and 79. Findings Include The "south hall insulin cart" was observed on 7/15/11 at 9:30 a.m. Two vials of insulin were found with dates that indicated they were more than 28 days past their original open dates.	F0425	**F425 483.60(a),(b) PHARMACEUTICAL SVC – ACCURATE PROCEDURES, RPH I. Resident #22, #29, #59 and #79 insulin was disposed of and replaced during the survey process. II. All residents receiving insulin have been identified and the vials have been reviewed for expiration date and date opened. No expired insulins were found. III. The systemic change includes: a. Licensed nursing staff will be educated on the importance of dating the**	08/14/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155412	A. BUILDING 00 B. WING	07/15/2011

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	One vial of Levemir Insulin, belonged to Resident #79. One vial of Novolog Insulin belonged to Resident #59. The "north, 100 hall" medication cart was observed on 7/15/11 at 10:00 a.m. Two vials of insulin were found with dates that indicated they were more than 28 days past their original open dates. One vial Novolog Insulin belonged to Resident #22. One vial of Novolog Insulin belonged to Resident #29. A facility policy reviewed on 7/15/11 at 5 p.m., un-dated and titled " Expiration Dates For Certain Drugs, Biologicals, and Records", indicated that Insulin expires 28 days after it's first use. 3.1-25(a)(1)		**insulin after being opened and checking the expiration date prior to administration. Each nurse administering insulin will check the expiration date prior to giving the injection. Each medication cart has been provided with a chart for quick reference for opened multi-dose medication expiration dates. Education will be provided for licensed nursing staff regarding insulin vial procedure. IV. The Director of Nursing or designee will review/audit: a. All medication administration carts for insulin vials with dates of opening and replacement by the 28 th day three times weekly for 1 month, then once weekly for 1 month, then once every other week for 1 month, and the once monthly for a duration of 12 months. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. V. Completion date: August 14, 2011**	